SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
Company Tracking Number:	*A4282605USMMAR01 01A*		
TOI:	*MS05G Group Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05G.001 Plan A*
Product Name:	*MEDICARE SUPPLEMENT*		
Project Name/Number:	*CO-MARKETING ENROLLMENT APPLICATIONS/A4282605USMMAR01 01A*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: MEDICARE SUPPLEMENT	SERFF Tr Num: UHLC-126021865	State: ArkansasLH
TOI: MS05G Group Medicare Supplement - Standard Plans	SERFF Status: Closed	State Tr Num: 41461
Sub-TOI: MS05G.001 Plan A	Co Tr Num: A4282605USMMAR01 01A	State Status: Filed-Closed
Filing Type: Advertisement	Co Status:	Reviewer(s): Stephanie Fowler
	Author: Bobbie Walton	Disposition Date: 02/05/2009
	Date Submitted: 02/04/2009	Disposition Status: Filed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: CO-MARKETING ENROLLMENT APPLICATIONS	Status of Filing in Domicile: Not Filed
Project Number: A4282605USMMAR01 01A	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 02/05/2009	
State Status Changed: 02/05/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: UNITED HEALTHCARE INSURANCE COMPANY

AARP Medicare Supplement Enrollment Application

Co-Marketing Material

NAIC No: 0707-79413

Our File No: A4282605USMMAR01 01A (PLEASE USE THIS NUMBER IN ALL CORRESPONDENCE)

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
Company Tracking Number:	*A4282605USMMAR01 01A*		
TOI:	*MS05G Group Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05G.001 Plan A*
Product Name:	*MEDICARE SUPPLEMENT*		
Project Name/Number:	*CO-MARKETING ENROLLMENT APPLICATIONS/A4282605USMMAR01 01A*		

Dear Ms. Bennett:

We enclose for your information and review, proof copies of an enrollment application for use in connection with the AARP group health insurance program. This enrollment application is new and does not replace any material previously submitted to the Department.

The definitions, disclosures, eligibility requirements, exclusions, limitations, Group Policy Form No. GRP 79171 GPS-1, as well as, the statement, "…not connected with, or endorsed by, the U.S. Government or the federal Medicare program," can be found in BA8982 DIS AR (02/06) which was approved by your Department on March 20, 2006.

Members who enroll in the AARP Medicare Supplement Plans will be issued certificates with Certificate Form Nos. MSA 1959, et al which were approved by your Department on September 1, 2005.

The attached list of enclosures indicates the contents of each package including the form number, and title of each item.

We trust the enclosed forms are in order and look forward to your prompt acknowledgment of this filing. If you have any further questions you can contact me at 267-470-1519. If you prefer, you may also send a facsimile to me at Fax: 267-470-1908 or send an email to Susan_J_Cipollo@uhc.com.

Sincerely,

Susan J. Cipollo
Director, Marketing Compliance

SJC:blw
Enclosures

ARKANSAS

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
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Project Name/Number:	*CO-MARKETING ENROLLMENT APPLICATIONS/A4282605USMMAR01 01A*		

LIST OF ENCLOSURES

MEDICARE SUPPLEMENT

CO-MARKETING ENROLLMENT APPLICATION

2009

A4282605USMMAR01 01A ENROLLMENT APPLICATION

BA8982 DIS AR (02/06) WRAP*

CV463 COVER PAGE**

FA528 – FA529, FA572 – FA581 OUTLINE OF COVERAGE***

*THIS COMPONENT WAS APPROVED BY THE DEPARTMENT ON 3/20/06 UNDER FILE NUMBER BA8982 DIS AR (02/06) AND YOUR DEPARTMENT FILE NUMBER 30566.

**THESE COMPONENTS WERE APPROVED BY THE DEPARTMENT ON 9/1/05 UNDER FILE NUMBER MSA 1959.

*** THIS COMPONENT WAS APPROVED BY THE DEPARTMENT ON 9/5/07 UNDER FILE NUMBER CV463.

Company and Contact

Filing Contact Information

Susan Cipollo, Director
601 Office Center Dr.
Fort Washington, PA 19034

Susan_J_Cipollo@uhc.com
(267) 470-1519 [Phone]
(267) 470-1906[FAX]

Filing Company Information

United HealthCare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(215) 653-8046 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
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Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	$20.00 per enrollment application - 1 enrollment application = $20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$20.00	02/04/2009	25503404

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
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Project Name/Number:	*CO-MARKETING ENROLLMENT APPLICATIONS/A4282605USMMAR01 01A*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	02/05/2009	02/05/2009

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
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Project Name/Number:	*CO-MARKETING ENROLLMENT APPLICATIONS/A4282605USMMAR01 01A*		

Disposition

Disposition Date: 02/05/2009
Implementation Date:
Status: Filed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
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Project Name/Number:	*CO-MARKETING ENROLLMENT APPLICATIONS/A4282605USMMAR01 01A*		

Item Type	Item Name	Item Status	Public Access
Form	Enrollment Application	Filed	Yes

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
Company Tracking Number:	*A4282605USMMAR01 01A*		
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Product Name:	*MEDICARE SUPPLEMENT*		
Project Name/Number:	*CO-MARKETING ENROLLMENT APPLICATIONS/A4282605USMMAR01 01A*		

Form Schedule

Lead Form Number: A4282605USMMAR01 01A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed	A4282605USMMAR01 01A	Application/ Enrollment Form	Enrollment Application	Initial		50	A4282605USMMAR010A.pdf

PERSONALIZED APPLICATION FOR <JOE SAMPLE>

AARP® MedicareRx Plans and AARP Medicare Supplement Insurance Plans Insured by United HealthCare Insurance Company.

<AARP Membership Number: 000000000000>

<Joe Sample>
<123 Main Street>
<Anytown, USA 12345-6789>

Please make any corrections to your name and address below. Please do not use P.O. boxes.

_____

_____

_____

The plans and rates described in this package are good only for the address indicated.

LET'S GET STARTED—SEND NO MONEY NOW

For Medicare prescription drug coverage (Part D)—COMPLETE SECTIONS 1A–8

For Medicare supplement coverage—COMPLETE SECTIONS 1B–3, 9 AND 10

For both—COMPLETE SECTIONS 1–10

Please check boxes in INK.

1 Select the coverage(s) that best meets your needs

1A
Medicare prescription drug coverage (Part D)

I wish to apply for the (select only one)

- ☐ **AARP MedicareRx Preferred**
- ☐ **AARP MedicareRx Enhanced**
- ☐ **AARP MedicareRx Saver**

See the "Summary of Benefits" insert for more information.

1B
Medicare supplement coverage

I wish to apply for the following AARP Medicare Supplement Insurance Plan (select only one)

- ☐ **Plan A**
- ☐ **Plan B**
- ☐ **Plan C**
- ☐ **Plan D**
- ☐ **Plan E**
- ☐ **Plan F**
- ☐ **Plan G**
- ☐ **Plan H**
- ☐ **Plan I**
- ☐ **Plan J**
- ☐ **Plan K**
- ☐ **Plan L**

See the "Outline of Medicare Supplement Coverage"–cover page insert for more information.

If return envelope is lost or misplaced, please mail this application to:
<United HealthCare Insurance Company, c/o AARP Health, P.O. Box 105331, Atlanta, GA 30348-5331>

Keep space clear for barcode

CONTINUE ON NEXT PAGE ▶

2 General information—please provide your Medicare insurance information

Provide your Medicare information

Please fill in these blanks so they match your Medicare card

—OR—

Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.

MEDICARE HEALTH INSURANCE

Name: ______________________________

Medicare Claim Number ☐☐☐ – ☐☐ – ☐☐☐☐☐

Sex ☐ M ☐ F

Is entitled to — Effective Date

HOSPITAL (Part A) ☐☐ – ☐☐ – ☐☐☐☐

MEDICAL (Part B) ☐☐ – ☐☐ – ☐☐☐☐

Are both Medicare Parts A and B active? ☐ Yes ☐ No

You may not yet have received your Medicare Card.
If this is the case, leave blank and move on to Section 3.

3 General information—tell us about yourself

Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **State** ☐☐ **Zip** ☐☐☐☐☐

Phone number ☐☐☐ – ☐☐☐ – ☐☐☐☐
(Area Code, Number)

Birthdate ☐☐ – ☐☐ – ☐☐☐☐
(Month, Day, Year)

Gender ☐ Male ☐ Female

Social Security # (Optional) ☐☐☐ – ☐☐ – ☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

E-mail address (optional)

Providing your e-mail address helps speed validation of information, if necessary, and indicates your interest in receiving information about your account and product offers via e-mail.

Best time to call ☐ Morning ☐ Afternoon ☐ Evening

CONTINUE ON NEXT PAGE ▶

4 Prescription drug coverage—please answer the following questions

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to one of our AARP MedicareRx Plans? ☐ Yes ☐ No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

Note: If you already have creditable coverage, as good as a standard Medicare Part D plan, you do not have to sign up for a Medicare Part D plan.

2. Do you, on your own or through your spouse, have any additional primary, supplemental, or liability plan other than Medicare that includes prescription drug coverage? ☐ Yes ☐ No
If "no," you may have to pay a Medicare late enrollment penalty. The AARP MedicareRx Plans may ask you to provide evidence that some or all of your previous prescription drug coverage was at least as good as Medicare drug coverage. If MedicareRx Plans asks you to provide proof of your previous coverage and you do not provide it, your premium may be increased because of late enrollment penalty. If you have questions about the late enrollment penalty, call the AARP MedicareRx Plans at 1-888-867-5564 <TTY: 1-877-730-4192, 24 hours a day, 7 days a week.> You may also visit www.medicare.gov or call 1-800-MEDICARE 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
AARP MedicareRx Plan information is available in different formats, including Spanish and large print. Please call UnitedHealthcare Customer Care at <1-XXX-XXX-XXXX> <TTY: 1-XXX-XXX-XXXX, 24 hours a day, 7 days a week> if you need plan information in another format or language.

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes," please provide the following information:

Name of Facility: _____

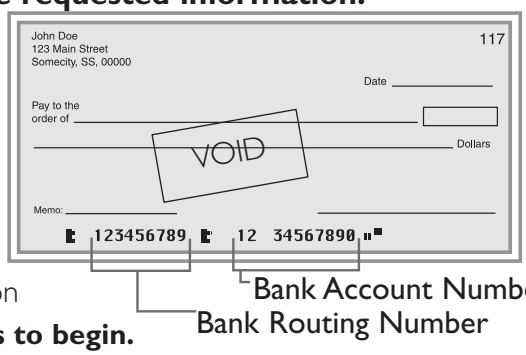
Address & Phone Number of Facility: _____

5 Prescription drug coverage—your plan premium payment options

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check, or you can pay through Electronic Funds Transfer from your checking, savings account, or choose a payment coupon book.

Please select one monthly payment option by checking the appropriate box below.
If you select Electronic Funds Transfer, please include the requested information.

☐ Electronic Funds Transfer from your bank account
(Please enclose a blank check with VOID written on the front.)
Account Holder Name: _____
Bank Routing Number: _____
Bank Account Number: _____
Account type: ☐ Checking ☐ Savings



☐ Payment coupon book for monthly payments by check
☐ Monthly Social Security Administration Benefit Check Deduction

The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If no option is chosen, you will receive a payment coupon book. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. If Medicare pays only a portion of this premium, please choose an option above for the remaining premium.

CONTINUE ON NEXT PAGE ▶

6 STOP Prescription drug coverage—please read this important information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage Plan that will meet your needs. By joining one of the AARP MedicareRx Plans, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you and, if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from a plan sponsor (former employer, union, or trust administrator), joining one of the AARP MedicareRx Plans could affect your employer or union health benefits. If you have health coverage from a plan sponsor, joining one of the AARP MedicareRx Plans may change how your current coverage works. Read the communications your plan sponsor sends you. If you have questions, visit their web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help. For AARP Medicare Enhanced plan, please note: you cannot enroll in this plan if your current or former employer helps pay for your prescription drugs.

7 Prescription drug coverage—please read and sign below

By completing this Enrollment Application, I agree to the following:

The AARP MedicareRx Plans are Medicare drug plans and have a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the AARP MedicareRx Plans of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare prescription drug plan, my enrollment in the AARP MedicareRx Plans will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (November 15–December 31), unless I qualify for certain special circumstances.

The AARP MedicareRx Plans serve specific service areas. If I move out of the area that the AARP MedicareRx Plans serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies to access the AARP MedicareRx Plans benefits, except under limited, non-routine circumstances when I cannot reasonably use the AARP MedicareRx Plans network pharmacies. Once I am a member of the AARP MedicareRx Plans, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from the AARP MedicareRx Plans when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with AARP MedicareRx Plans, he/she may be compensated based on my enrollment in the AARP MedicareRx Plans. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

If you are enrolling in the AARP MedicareRx Enhanced Plan:

By joining this plan, I attest that I am not receiving any financial support from my current or former plan sponsor (or my spouse's current or former plan sponsor) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.

CONTINUE ON NEXT PAGE ▶

7 Continued

Release of Information:
By joining this Medicare prescription drug plan, I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I acknowledge that the AARP MedicareRx Plans will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that (PDP name) will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this Enrollment Form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by the AARP MedicareRx Plans or by Medicare.

Signature:	**Date:**

If applicant is unable to sign, one witness signature is required.

Witness Signature:	**Telephone Number:**	**Date:**

8 Prescription drug coverage—authorized representative information

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign below and provide the following information:

Name:_____ **Date:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Signature:_____ **Phone:**_____

Relationship to Enrollee:_____

AARP MedicareRx Plans Use Only:

Plan ID #: _____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Employer ID #: _____ Branch ID #: _____

Marketing ID #: _____ Source Code: _____

Plan Representative/Agent/Broker Signature: _____

CONTINUE ON NEXT PAGE ▶

AARP Medicare Supplement Insurance Plans
Application page 1 of 4

Insured by United HealthCare Insurance Company, Horsham, PA 19044

9 Medicare supplement coverage—choose your start date

- **You are eligible to enroll if you are an AARP member, turning age 65, enrolling in Medicare Parts A and B, and not duplicating Medicare supplement coverage.** (You may apply using this form only if you are turning age 65 or first enrolling in Medicare Part B at age 65 or older.)
- Please refer to the enclosed cover page for the monthly cost of the plan you have selected. **SEND NO MONEY NOW.** You will be billed later.
- Your application must be received by the last day of the month in which you turn age 65 for you to receive your special birthday opportunity.
- **Your coverage will become effective on the first day of the month following receipt and approval of your completed application and first month's payment, but no sooner than the first day of your 65th birth month.** If your application is received more than six months after you turned age 65 or first enrolled in Medicare Part B at age 65 or older, you may have to answer medical questions. You will receive a Certificate of Insurance confirming your effective date. **(If you would like your coverage to begin at a later date, please indicate below.)**

Requested Effective Date (first of the future month) ☐☐ – **0 1** – ☐☐☐☐
(Month, Day, Year)

CONTINUE ON NEXT PAGE

10 Medicare supplement coverage—for your protection you are required to answer all the following questions and sign where indicated

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

CONTINUE ON NEXT PAGE ▶

10 Continued

Yes	No	
		Please answer all questions to the best of your knowledge.
		1a. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. If "yes," continue. If "no," go to question 2a.
		1b. Will Medicaid pay your premiums for this Medicare supplement policy?
		1c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
		2a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage Plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START M M D D Y Y Y Y END M M D D Y Y Y Y

		2b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
		2c. Was this your first time in this type of Medicare plan?
		2d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?
		3a. Do you have another Medicare supplement policy in force?
		3b. If "yes," do you intend to replace your current Medicare supplement policy with this policy?
		4a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)
		4b. If "yes," with what company and what kind of policy?

4c. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START M M D D Y Y Y Y END M M D D Y Y Y Y

		4d. Are you replacing the other health insurance indicated in question 4b?

CONTINUE ON NEXT PAGE

10 Continued

- My signature below indicates that I have read and understand the contents of this application.
- I declare that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if the answers are incomplete, incorrect, or untrue, United HealthCare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand that the coverage under the plan I am applying for will not take effect until issued by **United HealthCare Insurance Company, Horsham, PA 19044**

Note:
If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

Signature:	**Date:**

If return envelope is lost or misplaced, please mail to:
<United HealthCare Insurance Company, c/o AARP Health
P.O. Box 105331
Atlanta, GA 30348-5331>

SERFF Tracking Number:	*UHLC-126021865*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41461*
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Rate Information

Rate data does NOT apply to filing.